

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>150125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/11/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>901 MACARTHUR BLVD MUNSTER, IN 46321</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 27548 Facility Number: 005106</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey March 7 - 11, 2011</p> <p>Date of ISDH off site review - January 5, 2012</p> <p>Reviewer/Surveyor - Billie Jo Fritch RN, PHNS</p> <p>Based on review of the March 7 - 11, 2011 JCAHO Accreditation Survey Report, it has been determined that Community Hospital Munster meets the requirements for Hospital Licensure in Indiana.</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

L02E11

If continuation sheet 1 of 1